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Standing Committee A

NATIONAL HEALTH SERVICE REFORM AND HEALTH CARE PROFESSIONS BILL

Fourth Sitting

Thursday 29 November 2001

(Afternoon)

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Standing Committee A

Thursday 29 November 2001
(Afternoon)

[MR. ALAN HURST *in the Chair*]

NHS Reform and Health Care Professions Bill

2.30 pm

Ordered,

That the Order of the Committee of 27th November 2001 have effect as if for the second sitting on Thursday 29th November the order in the second column of the Table in which proceedings shall be taken shall be: Clause 6, Schedules 4 and 5, Clause 22, Clause 9, Clause 5, Schedule 2, Clauses 3 and 4, Schedule 3, Clause 10. — [*Mr. Hutton.*]

The Chairman: I draw hon. Members' attention to the fact that the resolution to which we have just agreed means that we shall start on page 135 of the amendment paper. When we have completed clause 9, we will then turn to clause 5 on page 134. Finally, we will turn to page 128.

Clause 6

LOCAL HEALTH BOARDS

The Parliamentary Under-Secretary for Wales (Mr. Don Touhig): I beg to move amendment No. 93, in page 8, line 10, at end insert—

'( ) Section 1 of the National Health Service (Private Finance) Act 1997 (c.56) (powers to enter into externally financed development agreements) applies to Local Health Boards as it applies to National Health Service trusts.'.

This is a technical amendment. It simply allows local health boards to enter into private finance arrangements in the same way that local health trusts are able to do.

Amendment agreed to.

Question proposed, That the clause, as amended, stand part of the Bill.

Mr. Touhig: Clause 6 will insert three new sections into the National Health Service Act 1977. New section 16BA will enable the National Assembly for Wales, by order, to establish statutory bodies to be known as local health boards and for those boards to exercise functions directed by the Assembly. Each board will be established in an area of Wales specified in the establishment order.

New section 16BB will empower the Assembly to direct local health boards to carry out specified functions that are currently carried out by health authorities. New section 16BC will enable the Assembly to direct local health board functions to be exercised on its behalf by, or jointly with, a number of other health bodies.

The clause will enable the Assembly to take a major step towards improving the national health service in Wales. It will help to develop the local health model and pave the way for achieving the reforms outlined in the NHS plan for Wales. The strengthening of local health groups, allied with a new sense of leadership and direction by the National Assembly, will deliver a key part of the NHS plan for Wales and follows from the Assembly's decision to abolish health authorities on 31 March 2003.

The establishment of local health boards is an essential part of the structural reform—

Mr. Simon Burns (West Chelmsford): Will the Minister confirm that health authorities in Wales will be abolished on 31 March 2003? If that is so, why does a different time scale apply in Wales from that which applies in England for the introduction of strategic health authorities?

Mr. Touhig: That is the way devolution works. The Assembly has set its own timetable for reform of the health service, and has already agreed, under the powers given to it in the Government of Wales Act 1998, to abolish health authorities in March 2003.

Mr. Burns: I understand what the Minister says, but does he have any knowledge of the reason behind the Assembly's decision? Did it not want to rush the introduction of the new structure into the health service in Wales?

Mr. Touhig: No. The Assembly made it clear that it wanted a new structure to run the health service in Wales, hence the clause, which will create the local health boards and do away with the five current health authorities. The Assembly has decided on the structure that it wants, following consultation. In the Queen's Speech, we highlighted the fact that a Bill on the NHS in Wales will follow in draft before too long, to add a lot of extra work that we want to ensure that we deliver to reform the health service in Wales. The clause appears in the Bill because it is time sensitive. It is designed so that the Assembly can meet its deadline of abolishing the health authorities on 31 March 2003. I hope that that satisfies the hon. Gentleman.

The local health boards are an essential part of the reform structure in Wales. They will have a stronger democratic voice and be more accountable for their actions. The arrangements that will result from the clause, and from clauses 9 and 22, will build on the valuable experience gained by local health groups during the past two years. From my constituency, I know that they have been extremely successful. They will open up new opportunities for doctors, nurses, other health professionals, local authorities, NHS trusts, the voluntary sector, carers and older people so that they can work together to assess the health needs of their communities and secure the services necessary to meet those needs.

The local health board model was developed in partnership with the key stakeholders as part of an implementation process to improve the health service in Wales. It was subject to wide public consultation, the findings of which reaffirmed the view that the local aspect of health care in Wales should be strengthened. Local health boards are the means to that end. The boards will be formed with local people and

[Mr. Touhig]

professionals who know their communities. They will be accountable to the local population to do all in their power to improve health and well-being.

The new level of accountability will be further underpinned by the statutory status of the boards, which will require them to demonstrate the highest standards of management, financial control and public probity. Local health boards will retain an important feature of local health groups, as they will be coterminous with local authority areas. That will allow them to develop new and better ways of working with local government and other stakeholders to improve the health service in Wales.

The development of local health boards and the well-being strategies that will follow from it are a key element in the reform of the NHS in Wales, and I commend the clause to the Committee.

Mr. Burns: I am grateful to the Minister for his explanation of the precise nature of the clause. Unless I am much mistaken, it lists the Welsh side of the reforms, and its effect and outlook are in many ways similar to what will happen in England.

As I mentioned, I was interested in the abolition of health authorities in Wales and the fact that the introduction of the local health boards in Wales will not happen until 31 March 2003. I find that fascinating, if only for the simple reason that Conservative Members have said consistently that SHAs in England should not come into effect until the day afterwards—1 April 2003—to avoid any haste. Unless the Minister can correct me, it seems as though that advice has been heeded in Wales, in effect, as one structure will not be abolished and replaced with another there until 18 months from now. The Welsh Assembly presumably feels that that is a longer and more responsible time scale on which to introduce such fundamental changes.

I would appreciate it if the Minister would elaborate on the precise reasoning and mechanics that the Welsh Assembly has gone through to reach this decision, so that it is out of sync by about six months.

I would also be grateful for some more information from the Minister about the mechanics of the matter. I see from subsection (1) and the Minister's explanatory note that when the boards are set up, the chair and the vice-chair will be appointed by the Assembly. I am interested in why it is felt that the Assembly rather than the local community or local structures within the NHS should take that decision.

The Minister also said, rightly, that the new system coming in in 2003 would mean that accountability to local communities would increase. It would be difficult to argue with the philosophy behind that. However, I would appreciate it if the Minister would flesh out what he means by greater accountability within the local community. Who will hold the bodies to account and establish this greater accountability? How much will the accountability be vested in local communities, as the Minister said, and what sort of accountability will there be to the Welsh Assembly?

What will the Assembly's powers be—I assume that the powers will be vested in the Assembly rather than in Ministers in the Wales Office—if there are problems with a health authority and intervention is needed to rectify any problems or any fall in standards of service provision? I make such comments in a probing and information-seeking spirit. I am not trying to open a keg of worms and cause problems. I am simply interested in how the system, which in many ways is similar to the English one, but in others is fundamentally different, will work.

Mr. Touhig: It is important to recognise that, as a result of the devolution settlement, the devolved Administrations will go down a different road from that taken by the Government in Westminster with regard to any reorganisation, particularly within the health service. That is no great problem. We have accepted the devolution settlement and we accept that the Assembly will go down its own road in respect of the powers that it has been given.

Mr. John Baron (Billericay): We do not disagree with the Welsh Assembly. We are not bringing the matter into the spotlight in order to ask why it should be different from us. We are suggesting that the fact that the Assembly has decided to delay the implementation of the reorganisation until April 2003 should suggest to the Government that the Assembly has grave doubts about bringing forward the reorganisation as we are doing in England. We are not disagreeing with the Welsh Assembly's right to make such a decision; we are saying that there is an implication that we, in England, are rushing through the reforms. That has been the thrust of our arguments on the Bill.

Mr. Touhig: I reassure the hon. Gentleman that that is not the case. The local health boards will be shadowing the other bodies before they actually take over their new responsibilities. The problem with the Welsh dimension is that there are many other reforms to the health service that the Assembly would like carried out. In the early discussions among the Wales Office, the Assembly and the Department of Health, the Assembly had a shopping list of items that it wanted included in this Bill and was prepared to consider a different time scale, if necessary. As I pointed out in response to an intervention from the hon. Member for West Chelmsford (Mr. Burns), the Government are committed to publishing a draft NHS Bill for Wales, which is not yet ready—we are still in discussions with the Assembly and the Department of Health on that. The Assembly has an extended time scale because many of the reforms that it would like carried out cannot be implemented until Parliament enacts that Bill.

Mr. Burns: What proportion of the reforms to which the Minister referred and that are needed in a draft Bill are actually beyond the scope of this legislation as it applies to Wales?

Mr. Touhig: I cannot directly answer the hon. Gentleman, because we are still in discussion about what should be included in the draft Bill. The

Assembly suggested a range of things that it would like to do but that we have not been able to include in this legislation. Clauses 6, which establishes the local health boards, and clause 22, which establishes the statutory partnerships requiring local authorities, health boards and trusts to work in partnership, are time sensitive. We are dealing with them now so that the shadow local health boards can be up and running and ready to take on their responsibilities by 2003. I cannot honestly say what will be included in the draft Bill.

2.45 pm

The hon. Gentleman made the point about the appointment of the chair and vice-chair of the local health board by the Assembly. The chairman will be independent in the sense that he will not be the person representing the Assembly in the health board, and the post will be advertised in the Nolan way. The appointment will be totally independent.

The hon. Gentleman also referred to the way in which boards will be accountable for their actions, and the greater degree of accountability in the community. The structure of local health boards will include representatives of health professionals. Only this week, during a debate in the Assembly, the secretary responsible for health agreed with an amendment moved by a representative of his party that determined that carers should also be represented on local health boards. Other health professionals and the local authority can also be represented, and it is believed that that will give the health service greater accountability, profile and visibility, which we welcome.

Each health board will be required to produce an annual report of its activities, and the Assembly, as we will see in clauses yet to be discussed, will have powers over the funding of the boards to ensure that they meet the Assembly's general strategy for health delivery. Obviously, the Assembly will be able to bring pressure to bear on the boards, as we will discuss in later clauses, to achieve the overall strategy and outcomes for reform of the health service.

This is an important reform of the health service for Wales. The local health groups have had an important influence on articulating local interests, hopes and desires for the reform and delivery of the health service. I am pleased about that because, in my constituency, in 1993, an ad hoc group produced the Islwyn local health plan, which identified the problems that we saw within the health service in my area. If some mechanism had been in place for delivering the solutions that were recommended, there would have been a great improvement in the health service in my constituency. I hope that local health boards will work after that kind of model, be responsive to the demands and hopes of the local communities and work in partnerships with the trusts to ensure that what people want is delivered.

Mr. Burns: Although the boards are called simply local health boards, will their primary function be strategic, similar to the SHAs that are being established in England?

Mr. Touhig: No, the local health boards will have responsibility for commissioning and delivering services.

Mr. Burns: So who or what body in Wales will have the function of strategically considering each aspect for the future of health care in that area?

Mr. Touhig: A director within the NHS will be responsible to the Assembly for ensuring that its strategic policies for health delivery in Wales are delivered.

Mr. Burns: I can understand that, but why were the Government not persuaded that the English model, which is one step divorced from this House and even from ministerial control, was not suitable in Wales? The sort of strategic planning that is emanating from the Welsh Assembly could be compared with the Department of Health taking over a strategic role in each region of the country—or whatever sub-geographical division one wanted to create. Would it not be better if strategic planning were undertaken one step lower, and closer to the area that would benefit—or otherwise—from its decisions on the provision of health care?

Mr. Touhig: Under the devolution settlement, it is the responsibility of the Assembly to make proposals for the reform of the health service in Wales in dialogue with the Department of Health. That formula has been agreed to be appropriate to deliver the improved health service that we seek in Wales.

Mr. Burns: I understand that, but I do not understand why it is thought better for SHAs in England to be independent of the Department of Health but not in Wales. It seems odd; if strategic health authorities are such a good idea for England, why are they not equally good for Wales?

Mr. Touhig: I can only reiterate that the Assembly takes the view that that is the most effective way of delivering the health service in Wales. It is a small country, with 3 million people and about dozen health trusts. We want to push down as much of the decision-making process as we can to the local health boards. Those boards will represent the interests of the whole community in order to deliver the hopes and aspirations for the health service in that community. It is a formula and a model that we believe will work in Wales.

Dr. Andrew Murrison (Westbury): Have the Government taken a view on which of the two different models that we have discussed they prefer? Which do they believe will deliver the best outcome? The differences have only just dawned on me. On the one hand there is the strategic health authority, which is effectively an ectopic part of the Department of Health sitting in the Welsh Assembly, and on the other the numerous strategic health authorities in the rest of England. It seems to me that they will work quite differently and I should be interested to know what the Govt think. We understand what the Welsh Assembly thinks but I want to know what the Government

[Dr. Andrew Murrison]

believe is the best model. If they think that the Welsh model is best, the natural corollary is to transpose it to England.

Mr. Touhig: The Government believe that both will be appropriate, because the devolution settlement allows the Assembly to define and decide its preferred route. It is as simple as that. Perhaps the hon. Gentleman has a problem coming to terms with the devolution settlement.

Mr. Dai Havard (Merthyr Tydfil and Rhymney): As a Member of Parliament in Wales, and until recently a trade union official dealing with people in the health service, including nursing groups and some of the professionals, I know of the great welcome that has been expressed on the involvement of local health boards. We are trying to get across the message that it will become a primary led service.

The local authority will have the legislative responsibility of producing a community strategy. That area will be coterminous with that of the health board, which has to produce a health and well-being strategy, and the two must work together. That is the power of the local connection, and of local people being involved in deciding what is important for their communities. The local authorities and boards will then co-operate with the local trust, of which there are only 12, and will commission the services from them for hospitals and so on. That level provides another strategic view. The NSH in Wales has not been organised as it is in the UK—

The Chairman: Order. The intervention is too long, but the hon. Gentleman will have a further opportunity to speak in the debate if he wishes.

Mr. Touhig: If I may help the Committee, primary care trusts exist in England, but not Wales. We are setting up local health boards, which will be the Welsh equivalent. People in England can already see the value of primary care trusts, and England is ahead of Wales in that regard. However, both approaches are perfectly valid given the devolution settlement in the United Kingdom.

Mr. Havard: I was trying to say that there will be a strategic vision, but it will be described differently.

Dr. Richard Taylor (Wyre Forest): Two days ago, we went over the difference between geographic boundaries and boundaries in size. If 3 million people is the right figure for Wales, I shall accept it because there are differences in size and concentration of population.

Mr. Touhig: Let me explain a little further what the NHS directorate will do. The Assembly views the strengthened directorate as part of the new relationship that will be developed with the NHS. It will ensure that a concerted effort is made at national and local level to deliver local services that provide national standards of care. That is the primary point that I want to get across to members of the Committee. We have had a useful debate. I have sought to answer hon. Members' questions properly, and I hope that they will support the clause.

Question put and agreed to.

Clause 6, as amended, ordered to stand part of the Bill.

Schedule 4

LOCAL HEALTH BOARDS

Question proposed, That this schedule be the Fourth schedule to the Bill.

Mr. Touhig: Schedule 4 on page 60 inserts new schedule 5B into the National Health Service Act 1977. It sets out provisions for local health boards as regards orders, status, membership and related matters. Under paragraph 5 on page 61, the Assembly will appoint the chairman and, if appropriate, the vice-chairman. Paragraph 13 on page 64 enables the local health boards to do whatever they consider necessary to exercise their functions. Paragraph 17 on page 64 enables the Assembly to make regulations that allow local health boards to produce reports, audit and publish accounts and publish other documents as required.

Mr. Burns: The Minister mentioned earlier that he expected the health boards to act as shadow health boards before 1 April 2003. Where are the statutory provisions to allow for that?

Mr. Touhig: I believe that they are in the existing legislation. When the Bill is enacted, the Assembly will have powers under existing legislation to bring the health boards into existence as shadow bodies.

Mr. Burns: Perhaps the Minister can help me because, as an English Member of Parliament, I am not that familiar with the issue. There are no powers in the Bill to allow health boards in Wales to act as shadow bodies, but how can there already be legislation to allow them to do so if there are no health boards in Wales at present?

Mr. Touhig: I believe that the legislation is already on the statue book and gives the Assembly devolved powers to do that. I am getting advice on the issue, which I shall share with the Committee. Local health groups—I am sorry, but I cannot read the writing. In any case, local health groups already exist as sub-committees of the five local health authorities. We shall enhance the functions of those groups so that they can act as shadow bodies.

Question put and agreed to.

Schedule 4 agreed to.

3 pm

Schedule 5

AMENDMENTS RELATING TO LOCAL HEALTH BOARDS

Mr. Touhig: I beg to move amendment No. 117, in page 68, line 14, at end insert—

'The Public Bodies (Admission to Meetings) Act 1960 (c.67)

In the Schedule to the Public Bodies (Admission to Meetings) Act 1960 (bodies to which the Act applies), after paragraph 1(gg) there is inserted—

"(gh) Local Health Boards;".

The Health Services and Public Health Act 1968 (c.46)

(1) Section 63 of the Health Services and Public Health Act 1968 (provision of instruction for officers of hospital authorities etc.) is amended as follows

(2) In subsection (1)(a), for "or Primary Care Trust" there is substituted ", Primary Care Trust or Local Health Board".

(3) In subsection (5A), for "or Primary Care Trust", in both places, there is substituted ", Primary Care Trust or Local Health Board".

(4) In subsection (5B), the "and" at the end of paragraph (bb) is omitted, and after that paragraph there is inserted—

"(bbb) Local Health Boards; and".

The Employers' Liability (Compulsory Insurance) Act 1969 (c. 57)

In section 3 of the Employers' Liability (Compulsory Insurance) Act 1969 (employers exempted from insurance), in subsection (2)(a)—

(a) for "1978 and" there is substituted "1978,", and

(b) after "1977" there is inserted "and a Local Health Board established under section 16BA of that Act".'.

The Chairman: With this it will be convenient to take Government amendments 118 to 121.

Mr. Touhig: Amendments Nos. 117 to 121 are essentially technical and consequential to existing legislation to cater for the creation of local health boards. The overall effect is to insert references to local health boards into existing legislation, so that the boards may exercise the appropriate powers and functions of their predecessor bodies and be subject to the appropriate duties existing under current legislation. These technical amendments also guarantee to the boards the necessary status to fulfil their role; the specific role and functions are a matter for the Assembly. I commend them to the Committee.

Mr. Baron: Opposition Members are concerned about the process of decentralisation, and the micromanagement of the PCTs in England by the Secretary of State. Can the Minister help us by explaining what performance targets, if any, will be given to the local health boards by the Welsh Assembly? Is there any micromanagement in that regard?

Mr. Touhig: I am not clear how the hon. Gentleman's question relates to these technical amendments, which seek to permit the amendment of existing legislation in order to take account of the creation of local health boards.

Mr. Baron: For that I apologise. However, I should like an answer to the question, although I appreciate that it does not apply to schedule 5.

The Chairman: Order. If it does not apply to the schedule, we should not take it at this point.

Mr. Touhig: If it helps the hon. Gentleman, I shall write to him explaining the point.

Question put and agreed to.

Amendments made: No. 118, in page 68, line 20, at end insert—

'In section 16C (advice for Health Authorities and Primary Care Trusts), in subsection (2), after "Primary Care Trusts" there is inserted "and Local Health Boards"

In section 22 (co-operation between health authorities and local authorities), in subsection (1A), the "or" at the end of paragraph (c) is omitted and after that paragraph there is inserted—

"(cc) a Local Health Board; or".

In section 23 (voluntary organisations and other bodies), in subsection (2), for "or Primary Care Trust" there is substituted ", Primary Care Trust or Local Health Board"

In section 26 (supply of goods and services by Secretary of State), in subsection (1)(b), for "or Primary Care Trust" there is substituted ", Primary Care Trust or Local Health Board"

In section 27 (conditions of supply under section 26)—

(a) in subsection (1), for "or Primary Care Trust", in both places, there is substituted ", Primary Care Trust or Local Health Board", and

(b) in subsection (3), for "and Primary Care Trusts" there is substituted "Primary Care Trusts and Local Health Boards".

In section 28 (supply of goods and services by local authorities)—

(a) in subsection (1), for "or Primary Care Trust" there is substituted "Primary Care Trust or Local Health Board", and

(b) in subsection (3), after "Primary Care Trusts", in both places, there is inserted ", Local Health Boards".

In section 28A (power to make payments towards expenditure on community services)—

(a) in subsection (1)—

(i) the "and" at the end of paragraph (a) is omitted, and

(ii) at the end of paragraph (b) there is inserted "; and", and after that paragraph there is inserted—

"(c) a Local Health Board.", and

(b) in subsection (2B), after "Primary Care Trust" there is inserted ", Local Health Board".

In section 28BB (power of local authorities to make payments to NHS bodies), in subsection (2), in the definition of "relevant NHS body", after "Primary Care Trust", there is inserted "or Local Health Board"

In section 51 (university clinical teaching and research)—

(a) in subsection (2), for "or Primary Care Trust", in both places, there is substituted ", Primary Care Trust or Local Health Board", and

(b) in subsection (3), the "and" at the end of paragraph (bb) is omitted and after that paragraph there is inserted—

"(bbb) Local Health Boards; and".

In section 84A (intervention orders), in subsection (2), after paragraph (d) there is inserted—

"(e) Local Health Boards.".

In section 84B (intervention orders: effect), in subsection (1), in each of paragraphs (a) and (b), for "or Primary Care Trust" there is substituted ", Primary Care Trust or Local Health Board"

In section 85 (Secretary of State's default powers), in subsection (1), after paragraph (bb) there is inserted—

"(bbb) a Local Health Board;".

In section 92 (further transfers of trust property), in subsection (1A), after paragraph (c) there is inserted—

"(cc) a Local Health Board;".

[Mr. Touhig]

In section 96A (power of health authorities etc. to raise money), in each of subsections (1), (3), (4), (7), (8) and (9), after "Special Health Authority", in each place where it occurs, there is inserted ", Local Health Board"

In section 98 (accounts and audit), in subsection (1), after paragraph (bb) there is inserted—

"(bbb) every Local Health Board;".

In section 99 (regulation of financial arrangements), in subsection (1), after paragraph (ba) there is inserted—

"(bb) Local Health Boards;".

In section 125 (protection of members and officers of authorities), the "and" at the end of paragraph (bb) is omitted and after that paragraph there is inserted—

"(bbb) a Local Health Board; and".

In paragraph 2 of Schedule 7 (which makes additional provision in relation to Community Health Councils)—

(a) in sub-paragraphs (d) and (e), after "Primary Care Trusts" , in each place where it occurs, there is inserted "Local Health Boards", and

(b) in sub-paragraphs (f) and (g), for "and Primary Care Trusts" there is substituted ", Primary Care Trusts and Local Health Boards".

The Acquisition of Land Act 1981 (c. 67)

In section 16 of the Acquisition of Land Act 1981 (statutory undertakers' land excluded from compulsory purchase), in subsection (3), the "and" at the end of paragraph (b) is omitted, and at the end of paragraph (c) there is inserted "and

(d) a Local Health Board established under section 16BA of that Act;".

The Hospital Complaints Procedure Act 1985 (c. 42)

In section 1 of the Hospital Complaints Procedure Act 1985 (hospital complaints procedure), in subsection (1B), after "Trust", where it first occurs, there is inserted "and Local Health Board", and in the second place where it occurs there is inserted "or Local Health Board"

The Income and Corporation Taxes Act 1988 (c.1)

In section 519A of the Income and Corporation Taxes Act 1988 (health service bodies), in subsection (2), after paragraph (ab) there is inserted—

"(aba) a Local Health Board;".

The Housing Act 1988 (c. 50)

In Schedule 2 to the Housing Act 1988 (grounds for possession of dwelling-houses let on assured tenancies), in the second paragraph of Ground 16, after "1990," there is inserted "or by a Local Health Board,"

The Road Traffic Act 1988 (c. 52)

In section 144 of the Road Traffic Act 1988 (exceptions from requirement of third-party insurance or security), in subsection (2)(da), after "1977" there is inserted ", by a Local Health Board established under section 16BA of that Act".'

No. 119, in page 68, line 21, at end insert—

'The National Health Service and Community Care Act 1990 is amended as follows.'

No. 120, in page 68, line 22, leave out

'the National Health Service and Community Care Act 1990, in'.

No. 121, in page 68, line 24, at end insert—

In section 8 (transfer of property, rights and liabilities to NHS trust)—

(a) in subsections (1), (2), (3), and (5), for "or Primary Care Trust" there is substituted "Primary Care Trust or Local Health Board", and

(b) in subsection (6)—

(i) in paragraph (a), after "Health Authority" there is inserted ", Local Health Board", and

(ii) for "or Primary Care Trust" there is substituted ", Primary Care Trust or Local Health Board".

In section 21 (schemes for meeting losses and liabilities of certain health service bodies), after paragraph (aaa) there is inserted—

"(aab) Local Health Boards;".

In section 49 (transfer of staff from health service to local authorities), in subsection (4)(b), after "Health Authority" there is inserted ", Local Health Board"

In section 61 (health service bodies: taxation), in subsection (3), after "Primary Care Trust" there is inserted "or Local Health Board"

(1) Schedule 2 (National Health Service trusts) is amended as provided in this paragraph

(2) In paragraph 4, for "or Primary Care Trust", in both places, there is substituted "Primary Care Trust or Local Health Board".

(3) In paragraph 13, after "Primary Care Trust" there is inserted "or Local Health Board,".

(4) In paragraph 30(1), after paragraph (bbb) there is inserted—

"(bbc) a Local Health Board, or".

Welsh Language Act 1993 (c. 38)

In section 6 of the Welsh Language Act 1993 (meaning of "public body"), in subsection (1), after paragraph (f) there is inserted—

"(ff) a Local Health Board established under section 16BA of the National Health Service Act 1977;".

The Health Service Commissioners Act 1993 (c. 46)

In the Health Service Commissioners Act 1993, in section 2 (bodies subject to investigation), in subsection (2), for paragraph (aa) there is substituted—

"(aa) Local Health Boards,".

The Vehicle Excise and Registration Act 1994 (c. 22)

In Schedule 2 to the Vehicle Excise and Registration Act 1994 (exempt vehicles), in paragraph 7, at the end of sub-paragraph (d) there is inserted "or

(e) a Local Health Board established under section 16BA of that Act.".

The Value Added Tax Act 1994 (c. 23)

In section 41 of the Value Added Tax Act 1994 (application to Crown), in subsection (7), after "Primary Care Trust" there is inserted "and a Local Health Board"

The Data Protection Act 1998 (c. 29)

In section 69 of the Data Protection Act 1998 (meaning of "health professional"), in subsection (3), after paragraph (bb) there is inserted—

"(bbb) a Local Health Board established under section 16BA of that Act,".

The Government of Wales Act 1998 (c. 38)

(1) The Government of Wales Act 1998 is amended as provided in this paragraph

(2) In Schedule 5 (bodies and offices covered by section 74), after paragraph 25 there is inserted—

"25A. A Local Health Board"

(3) In Schedule 17 (audit etc. of Welsh public bodies), after paragraph 12 there is inserted—

"12A. A Local Health Board."

The 1999 Act

In section 31 of the 1999 Act (arrangements between NHS bodies and local authorities), in subsection (8), in the definition of "NHS body", after "Primary Care Trust", there is inserted ", Local Health Board"

The Care Standards Act 2000 (c. 14)

In section 121 of the Care Standards Act 2000 (general interpretation), in subsection (1), in the definition of "National Health Service Body", for "or a Primary Care Trust" there is substituted ", a Primary Care Trust or a Local Health Board"

The Learning and Skills Act 2000 (c. 21)

In section 138 of the Learning and Skills Act 2000 (Wales: provision of information by public bodies), in subsection (3), after paragraph (b) there is inserted—

"(ba) a Local Health Board,".

The Freedom of Information Act 2000 (c. 36)

In Schedule 1 to the Freedom of Information Act 2000 (public authorities for the purposes of the Act), in Part 3 (National Health Service), after paragraph 39 there is inserted—

"39A. A Local Health Board established under section 16BA of the National Health Service Act 1977."

Health and Social Care Act 2001 (c. 15)

The Health and Social Care Act 2001 is amended as follows

In section 7 (functions of overview and scrutiny committees), in subsection (4), after "Primary Care Trust" there is inserted ", Local Health Board"

In section 46 (directed partnership arrangements), in subsection (5), in the definition of "NHS body", after "Primary Care Trust" there is inserted ", Local Health Board".'—[*Mr. Touhig.*]

Schedule 5, as amended, agreed to.

Clause 22

HEALTH AND WELL-BEING STRATEGIES IN WALES

Question proposed, That the clause stand part of the Bill.

Mr. Touhig: The clause places a duty on the newly formed local health boards in Wales, and on each local authority in Wales jointly to formulate and implement a health and well-being strategy for the local authority area. The clause reinforces the Assembly's commitment to joint working between the NHS and local government. In doing so, it seeks to embrace the wider stakeholder group, including the independent and voluntary sectors and others in setting the strategic agenda for health and well-being in their local areas.

The model for the health and well-being strategies emerged from the NHS plan in Wales. It is an inclusive model, which has been developed in partnership with stakeholders. Indeed, a task and finish group was created, comprising representatives of the NHS, local government, professional bodies and others, including the voluntary and independent sectors. These proposals have been brought forward as a consequence of that consultation. There has also been formal public consultation through the document "Structural Change in the NHS in Wales", which was published in July.

The emphasis on partnership working also derives from the joint working provisions of the Health Act 1999. The partnership provisions in sections 26 to 32 of that Act were intended to strengthen partnership working within the national health service and between the NHS and local government. Those provisions encouraged collaboration between the two statutory bodies, but did not require it. Nor did they require local authorities or NHS bodies to consult or otherwise involve external partners, such as the private and voluntary sector, in strategic or operational planning of services. Those are increasingly important elements of the overall health, well-being and care provisions in each local area. The clause is intended to redress the balance in Wales.

The development and implementation of the health and well-being strategies will ensure that all the relevant local partners are included in work on a strategic approach to the development and provision of the whole spectrum of services, from community care and primary health care to the acute sector and long-term domiciliary or residential care. Those strategies will reflect the need to tackle the underlying factors that lead to poor health, such as poor housing, poor education and unemployment. In so doing, they will contribute to the improvement of health services, to increased well-being and prosperity, and to a reduction in health inequalities.

The health and well-being strategy will complement the community strategies that local authorities are required to prepare under section 4 of the Local Government Act 2000. I commend the measure to the Committee.

Mr. Burns: I fully understand that the overall aim of the clause is to draw up strategies, in conjunction with local authorities and others, to enhance and improve the health of the community. Will the Minister explain what he envisages? Will there be overall strategies, or targets and aims to be reached in a specified time scale? If the latter approach has any role in the strategies, how will success be tested? How would failure to achieve the aims of the strategy be dealt with?

Mr. Touhig: It is important to recognise that the Assembly will set its overall priorities among its targets for improving health service delivery in Wales. It will establish measures for the achievement of targets and to assess the results. The Assembly will make regulations that will determine the targets and how they will be measured. As I said earlier, provision is made for local health boards to produce reports and to be open and accountable for all that they do. That will be measured not only against the Assembly's aims for the health service in Wales but against the hopes and aspirations of the local community, as represented on the local health boards.

Dr. Taylor: I strongly commend the power under clause 22(6)(a) for imposing a duty to consult, among others, community health councils, voluntary bodies and local businesses in Wales.

Question put and agreed to.

Clause 22 ordered to stand part of the Bill.

Clause 9

FUNDING OF LOCAL HEALTH BOARDS

Question proposed, That the clause stand part of the Bill.

Mr. Touhig: Clause 9 provides for the funding of local health boards, the setting of the financial duties and the establishment of resource limits. The clause closely mirrors the existing clause 97 in the National Health Service Act 1977 for the funding of health authorities. The clause provides for local health boards to be funded by the Assembly to secure health care for their populations. It also provides for the Assembly to fund up to the amount that is allocated, and also allows for the initial allocation to be adjusted during the year. It provides for the Assembly to make payments to local health boards on their performance, based on specific objectives or criteria. The Assembly will be required to notify local health boards in advance of those criteria if additional payments are

[Mr. Touhig]

intended to be made on that basis. Part or all of the performance funding will be able to be withdrawn if, subsequent to the additional allocation, the local health board partially or wholly fails to satisfy the set criteria.

When determining local health board allocations, the clause allows for the Assembly to take into account the local health board's expenditure on non-cash-limited funding, which is part 2 expenditure. In addition, it provides for local health boards to pay capital charges to the Assembly and allows the Assembly to ring-fence parts of the allocation for specific purposes. As well as establishing the funding mechanism, it establishes a duty on local health boards not to exceed the sum allocated to them by the Assembly plus any other receipts. It also extends the setting of resource limits to local health boards, as provided for in the Government Resources and Accounts Act 2000. I commend the clause to the Committee.

Mr. Burns: I apologise in advance if I am displaying an excess of ignorance about the Welsh Assembly. Is there a mechanism in the Welsh Assembly so that, if it wanted to, it could provide free residential care for the people of Wales in the same way that the Scottish Parliament can for the people of Scotland?

Mr. Touhig: Yes, it has the power.

Mr. Burns: If the Welsh Assembly decided that it wished to provide free residential care in the same way as is anticipated in Scotland, it would be contrary to Government policy for England. Is there any funding mechanism that the Department of Health in London could use to restrict the money paid to the Welsh Assembly for Welsh health care because it disapproved of decisions taken by the Welsh Assembly?

Mr. Touhig: What the Welsh Assembly does on that matter is for the Welsh Assembly. The responsibilities are devolved under the Government of Wales Act 1998. The Assembly can make its own decisions and would have to find its own finances for the scheme.

Mr. Burns: The Minister says that the Assembly would have to find its own finances for such a project. Presumably, the money that the Department of Health, or the Treasury, in London gives to the Welsh Assembly to provide health care in Wales is categorised. I imagine that there are rules and regulations about what the money can be spent on. Could the Welsh Assembly spend money sent by the Treasury for health care on another non-health related spending priority? Surely the money is ring fenced in one way. Is it not the case that the Treasury provides money for health care, which the Welsh Assembly devolves throughout the Principality of Wales to provide health care?

I will round the figures to make it simple. Let us imagine that the Government give £1 billion for health care in Wales on the criteria of maintaining current provision. The Welsh Assembly decides to provide free residential care for the elderly next year, which, for sake of argument, costs £500 million and comes out of the health budget sent by the Treasury. The Assembly would be £500 million short to maintain the same level of health care in the Principality, and that would be a problem. If that is the logic, given that the Government in London do not agree that residential care should be provided free at taxpayers' expense out of Department of Health funds, how could we get around it?

Mr. Touhig: The hon. Gentleman will forgive me for going over what happened in 1998 when we passed the Government of Wales Act. Funding decisions for the Welsh Assembly derive from the Barnett formula and the Assembly has complete autonomy in deciding how to spend the money. Decisions to increase public spending on health will have consequential effects on the Barnett formula that carry over into Wales, but the Assembly can determine whether to use the money for health or something else. Under the devolved settlement, it is entirely within the power of the Assembly.

Question put and agreed to.

Clause 9 ordered to stand part of the Bill.

Clause 5

LOCAL REPRESENTATIVE COMMITTEES

3.15 pm

The Minister of State, Department of Health (Mr. John Hutton): I beg to move amendment No. 115, in page 5, line 32, leave out '(1A)' and insert '(1ZA)'.

The Chairman: With this we may take Government amendment No. 116.

Mr. Hutton: The amendments are minor and consequential. They correct minor typographical errors in subsection (9), which inserts a new subsection (1A) into section 45 of the 1977 Act. We have a slight problem because of an existing subsection (1A), so amendment No. 115 simply corrects the reference to subsection (1Z). Amendment No. 116 makes a minor and consequential change to subsection (10) in order to reflect the changes made under amendment No. 115.

Question put and agreed to.

Amendment made: No. 116, in page 5, line 43, after '(1A)' insert—

'(a) for "power conferred by subsection (1) above is" there is substituted "powers conferred by subsections (1) and (1ZA) above are", and

(b)'. —[*Mr. Hutton.*]

Clause 5, as amended, ordered to stand part of the Bill.

Schedule 2

REALLOCATION OF FUNCTIONS OF HEALTH AUTHORITIES TO PRIMARY CARE TRUSTS

Mr. Hutton: I beg to move amendment No. 97, in page 48, line 5, leave out from '2' to end of line and insert—

'(1) Section 15 (duty of Health Authority in relation to family health services) is amended as provided in this paragraph.

(2)'.

The Chairman: With this we may take Government amendments Nos. 98 to 106.

Mr. Hutton: Again, these are purely minor and consequential amendments, which substitute or add the words "primary care trust" in place of references to health authorities in the relevant statutes. Amendments Nos. 102 and 103 make minor changes to ensure consistency in the schedule's layout.

Question put and agreed to.

Amendments made: No. 98, in page 48, line 6, leave out

'each of subsections (1) and (1ZA)'

and insert 'subsection (1)'.

No. 99, in page 48, line 7, at end insert—

'(3) In subsection (1B)—

(a) before "Health Authority", in each place where it occurs, there is inserted "Primary Care Trust or",

(b) for "that Authority's medical list" there is substituted "the medical list of that Trust or Authority", and

(c) for "that Authority" there is substituted "that Trust or Authority".

(4) In subsection (1BA)—

(a) after "relevant" there is inserted "Primary Care Trust or", and

(b) for "the Authority" there is substituted "the Trust or Authority".

(5) Sub-paragraphs (3) and (4), and this sub-paragraph, shall cease to have effect on the coming into force of paragraph 8 of Schedule 4 to the 1999 Act (which repeals subsections (1B) to (1D) of section 15 of the 1977 Act).'.

No. 100, in page 55, line 3, at end insert—

'PART 2

AMENDMENTS OF OTHER ACTS

The National Assistance Act 1948 (c. 29)

In section 26 of the National Assistance Act 1948 (provision of accommodation in premises maintained by voluntary organisations), in subsection (1C), after "consent of such" there is inserted "Primary Care Trust or"

The Reserve and Auxiliary Forces (Protection of Civil Interests) Act 1951 (c. 65)

In Part 1 of Schedule 2 to the Reserve and Auxiliary Forces (Protection of Civil Interests) Act 1951 (which makes provision about payments to make up civil remuneration), in paragraph 16, in the entry in the second column, before "Health Authority" there is inserted "Primary Care Trust,"

The Health Services and Public Health Act 1968 (c. 46)

(1) The Health Services and Public Health Act 1968 is amended as provided in this paragraph.

(2) In section 63 (provision of instruction for certain persons), in subsection (2)(b), before "Health Authority" there is inserted "Primary Care Trust or".

(3) In section 64 (financial assistance to certain voluntary organisations), in subsection (3)(b), before "Health Authority" there is inserted "Primary Care Trust or".

The Health and Safety at Work etc Act 1974 (c. 37)

In section 60 of the Health and Safety at Work etc Act 1974 (which makes supplementary provision in relation to the employment medical advisory service), in subsection (1), after "that each" there is inserted "Primary Care Trust and"

The Mental Health Act 1983 (c. 20)

The Mental Health Act 1983 is amended as follows.

In section 25A (applications for supervision), before "Health Authority", in each place where it occurs, there is inserted "Primary Care Trust or"

In section 25C (supervision applications: supplementary), in subsection (6), after "consent of the" there is inserted "Primary Care Trust or"

In section 25F (reclassification of patient subject to after-care under supervision), in subsection (1), after "effect to the" there is inserted "Primary Care Trust or"

In section 39 (information as to hospitals), in subsection (1), before "Health Authority", in each place where it occurs, there is inserted "Primary Care Trust or"

In section 117 (after-care), in each of subsections (2), (2A) and (3), before "Health Authority", in each place where it occurs, there is inserted "Primary Care Trust or"

In section 140 (notification of hospitals having arrangements for reception of urgent cases)—

(a) after "duty of" there is inserted "every Primary Care Trust and of",

(b) for "Health Authority's area" there is substituted "area of the Primary Care Trust or Health Authority", and

(c) after "available to the" there is inserted "Primary Care Trust or".

In section 145 (interpretation), in paragraph (a) of the definition of "the managers", before "Health Authority" there is inserted "Primary Care Trust,"

The Public Health (Control of Disease) Act 1984 (c. 22)

(1) The Public Health (Control of Disease) Act 1984 is amended as provided in this paragraph.

(2) In section 11 (cases of notifiable disease and food poisoning to be reported), before "Health Authority", in each place where it occurs, there is inserted "Primary Care Trust or".

(3) In section 12 (fees for certificates under section 11), in subsection (1), after "that a" there is inserted "Primary Care Trust or".

(4) In section 39 (keeper of common lodging-house to notify case of infectious disease), in subsection (3), after "to the" there is inserted "Primary Care Trust or".

The Disabled Persons (Services, Consultation and Representation) Act 1986 (c. 33)

In section 7 of the Disabled Persons (Services, Consultation and Representation) Act 1986 (persons discharged from hospital), in subsection (9), for paragraph (a) of the definition of "health authority" there is substituted—

"(a) in relation to England, means a Primary Care Trust,

(aa) in relation to Wales, means a Health Authority, and".

The Children Act 1989 (c. 41)

In Schedule 2 to the Children Act 1989 (local authority support for children and families), in paragraph 1A(3)(a), for "and" there is substituted "or"

The National Health Service and Community Care Act 1990 (c. 19)

The National Health Service and Community Care Act 1990 is amended as follows.

In section 4A (provision of certain services by persons on ophthalmic or pharmaceutical lists), in subsection (1), after "a Strategic Health Authority," (inserted by Schedule 1 to this Act) there is inserted "a Primary Care Trust,"

(1) In section 18 (indicative amounts for doctors' practices)—

(a) in subsection (1)—

(i) after "financial year," there is inserted "every Primary Care Trust and", and

(ii) before "Health Authority", in the second and third places it occurs, there is inserted "Primary Care Trust or",

[Mr. Hutton]

(b) before "Health Authority", in each other place where it occurs except in subsection (7), there is inserted "Primary Care Trust or", and

(c) in subsection (7), for "Health Authority" there is substituted "Primary Care Trust".

(2) This paragraph shall cease to have effect on the coming into force of paragraph 80 of Schedule 4 to the 1999 Act (which repeals section 18 of the National Health Service and Community Care Act 1990).

In section 47 (assessment of needs for community care services), in subsection (3)—

(a) before "Health Authority", where it first occurs, there is inserted "Primary Care Trust or", and

(b) before "Health Authority", in each other place where it occurs, there is inserted "Primary Care Trust,".

In section 49 (transfer of staff from health service to local authorities), in subsection (4)(b), after "Strategic Health Authority," (inserted by Schedule 1 to this Act) there is inserted "Primary Care Trust,"

In Schedule 2 (which makes provision about NHS trusts), in paragraph 31, after "Strategic Health Authority" (inserted by Schedule 1 to this Act) there is inserted "Primary Care Trust,"

The Access to Health Records Act 1990 (c. 23)

(1) The Access to Health Records Act 1990 is amended as provided in this paragraph.

(2) In section 1 (definitions of certain terms), in subsection (2)(a)(ii), before "Health Authority" there is inserted "Primary Care Trust,".

(3) In section 7 (duty of health service bodies etc to take advice), before "Health Authority", in each place where it occurs, there is inserted "Primary Care Trust,".

The Trade Union and Labour Relations (Consolidation) Act 1992 (c. 52)

In section 279 of the Trade Union and Labour Relations (Consolidation) Act 1992 (health service practitioners), in paragraph (a), before "Health Authority" there is inserted "Primary Care Trust or"

The Health Service Commissioners Act 1993 (c. 46)

(1) The Health Service Commissioners Act 1993 is amended as provided in this paragraph.

(2) In section 2 (bodies subject to investigation)—

(a) in subsection (1), in paragraph (da), "established for areas in England" is omitted, and

(b) in subsection (2), in paragraph (a), "whose areas are in Wales" is omitted.

(3) In section 6 (which provides for certain action by Health Authorities, etc not to be investigated), in each of subsections (3) and (5), after "taken by a" there is inserted "Primary Care Trust or".

The Health Authorities Act 1995 (c. 17)

In Schedule 2 to the Health Authorities Act 1995 (transitional provisions and savings), in paragraph 2, before "Health Authority", in each place where it occurs, there is inserted "Primary Care Trust,"

The Employment Rights Act 1996 (c. 18)

In section 43K of the Employment Rights Act 1996 (extended meaning of "worker" for Part 4A of that Act), in subsection (1)(c)(i), before "Health Authority" there is inserted "Primary Care Trust or".'.

No. 101, in page 55, line 7, at end insert—

'The School Standards and Framework Act 1998 (c. 31)

In Schedule 9 to the School Standards and Framework Act 1998 (which provides for the constitution of school governing bodies), in paragraph 10 (community special schools), in sub-paragraph (5)(a), after "by the" there is inserted "Primary Care Trust or"

The Government of Wales Act 1998 (c. 38)

(1) The Government of Wales Act 1998 is amended as provided in this paragraph.

(2) In Schedule 5 (bodies and offices covered by section 74), in paragraph 20, "for an area in, or consisting of, Wales" is omitted.

(3) In Schedule 17 (audit, etc, of Welsh public bodies), in paragraph 12, "for an area in, or consisting of, Wales" is omitted.".'

No. 102, in page 55, line 8, at end insert—

'The 1999 Act is amended as follows.'

No. 103, in page 55, line 9, leave out

'of the Health Act 1999'.

No. 104, in page 55, line 12, at end insert—

'The Care Standards Act 2000 (c. 14)

In section 20 of the Care Standards Act 2000 (urgent procedure for cancellation, etc of registration of establishment or agency), in subsection (6)(b), before "Health Authority" there is inserted "Primary Care Trust or".'

No. 105, in page 56, line 12, at end insert—

'In Schedule 1 (exempt information relating to health services), in paragraph 10, after "by a" there is inserted "Primary Care Trust or".'

No. 106, in page 56, line 39, at end insert—

'In Schedule 5 (minor and consequential amendments), in paragraph 9, before "Health Authority", in both places, there is inserted "Primary Care Trust or".'—[*Mr. Hutton.*]

Schedule 2, as amended, agreed to.

Clause 3

DIRECTIONS: DISTRIBUTION OF FUNCTIONS

Mr. Hutton: I beg to move amendment No. 91, in page 3, line 25, leave out '(2)(a)' and insert '(3)(a)'.

Once again, it is a minor, purely consequential amendment to correct a cross-reference in the original drafting.

Question put and agreed to.

3.19 pm

Sitting suspended for a Division in the House.

3.35 pm

On resuming—

Mr. Burns: I beg to move amendment No. 123 in page 3, line 31, at end insert—

'(6) No functions shall be distributed to or exercisable by a Primary Care Trust unless the Secretary of State has laid before each House of Parliament a statement to the effect that such Primary Care Trust is ready, willing and able to receive and exercise such functions.'.

I will try not to give this debate an air of de"jà vu by referring to an earlier debate. This deals with the question of whether the negative or affirmative resolution is used to approve the secondary legislation that fleshes out some of the powers given to the Secretary of State to enact the Bill.

Clause 3 gives the powers for the transfer of functions to the strategic health authorities and PCTs to carry out their newly defined duties under the Bill. We must also bear in mind the contents of schedule 2. Not only does the clause give the Secretary of State the powers to delegate directly to PCTs the exercise of any functions conferred on him by health authorities, including things like providing hospital accommodation, but there is a range of duties and

functions in schedule 2 that will be carried out under the powers contained in the clause. All hon. Members will accept that this is an extremely important part of the Bill, because it provides the powers to ensure that the Bill fulfils its objectives and that the relevant bodies and organisations have the statutory basis to carry out their duties.

Those powers are given through secondary legislation, which again is carried out by negative procedures. My hon. Friends and I would argue that given the significance of the powers in this clause, the negative procedure is just not the right way to proceed. In an earlier debate on a similar clause with regulation-making powers, we pointed out that just over 2,000 statutory instruments laid before Parliament in the last Session required the negative procedures. The vast majority of them never had the opportunity to be debated in the House or another place. From memory, I think that about 30 statutory instruments subject to the negative procedure were debated in the House.

If one looks at the situation in the context of the proper monitoring and holding to account of legislation, I hope that the Minister will agree that it is unsatisfactory to use secondary legislation to enact parts of primary legislation that has been studied line by line in Committees such as this. The same argument applies as before. When the Minister was in opposition, in Committee after Committee on Bill after Bill, he and his shadow ministerial colleagues clamoured for more Government accountability to Parliament on significant pieces of secondary legislation. It was unacceptable that they should slip through almost on the nod by the negative procedure. Ten years ago, the Minister would have agreed 100 per cent. with every word that I am saying, but life has moved on and things have changed. He now has the responsibilities and I do not, so the arguments that Labour Members and possibly the Minister made in Committee at the time are no longer regarded as valid.

We cannot remain in a time warp. One should always be sufficiently intellectually alert to challenge perceived views when life moves on, and this is one of those times. I hope that the Minister agrees that the powers in the clause are crucial and warrant a more careful study by Parliament before being enacted. That could be done only by changing the negative procedure envisaged by Ministers into the affirmative procedure, so that we and another place have an opportunity to study what the Government are proposing and to ensure that they have got it right.

Even though a statutory instrument cannot be amended, it can be withdrawn if it is shown that there are significant flaws in any of its proposals, and it can be redrafted. However, we have the opportunity to prevent potential pitfalls only if we have a debate in a Committee, so that we can study the statutory instrument. If the negative procedure applies, according to the law of averages the past figures that I have quoted show that the chances of having a debate are negligible.

The Minister would be in an unenviable position if a statutory instrument gave the Government the powers to bring in the provisions, and a glaring error or fatal flaw in the proposals was suddenly discovered afterwards. If the amendment were accepted, this Minister in particular would be more than anxious to thank me for helping him to avoid that pitfall and the tarnishing of the justifiable and reasonable reputation that he enjoys as a Minister of State in the Department of Health.

With the intellectual power of persuasion and a little flattery, I hope that the Minister will be reasonable enough to agree that my case for the amendment is overwhelming. In the long run, it would help him to avoid any pitfalls that parliamentary draftsmen, civil servants or Ministers looking through their boxes late at night had missed. I hope that for the common good and to avoid mistakes being found when it is too late, he will accept the amendment.

Mr. Hutton: I am grateful for the flattery by the hon. Member for West Chelmsford. I always enjoy flattery and I particularly enjoyed that moment, so perhaps he would like to repeat it.

Mr. Burns: I will if it works.

Mr. Hutton: It very nearly did. I was seriously tempted to accept the amendment, but then I realised that the hon. Gentleman was over-egging the pudding just a little and I pulled back towards the end of his remarks.

I understand where the hon. Gentleman is coming from. He made clear his views on the general issue earlier, and I have set out my views on it as well. As always, we need to consider the amendment before us, not the general principle that underpins it, for which many of us may express some support. The Committee is charged with considering the amendment.

The hon. Gentleman asks for the affirmative resolution procedure to apply. The amendment would require the Secretary of State to make a statement to the House that a PCT was ready, willing and able to receive and exercise the relevant functions. However, those are matters of judgment. They are not about the wording or otherwise of any regulation, so I am not sure that his point about improved scrutiny of the wording or technical drafting of regulations is relevant to the amendment. He is asking the House to make a judgment on the suitability or otherwise of PCTs. That is different argument from the one about improving the scrutiny of regulations. He has again chosen the wrong issue and the wrong amendment to make his point. The amendment was a vehicle for making the same general observations, and he has done that. I will not bore the Committee with another long description of my reasons why the amendment should not be accepted, I simply refer him to my earlier remarks. The hon. Gentleman has not raised any issue of substance or any different issue of principle. I do not want to leave him feeling disappointed or somehow chastised. I will find another occasion to flatter him. Indeed, I want to flatter him, but he will have to make it easier for me to do that.

[Mr. Hutton]

3.45 pm

I pay tribute to the hon. Gentleman and hope that that might help him. He talked about the need for us to be intellectually alert. He always is, and has a fine reputation in the House for that. I know how difficult it must be for him today, because I understand that he is trying to give up smoking. I gave up smoking, and know how difficult it is. I did not feel especially intellectually alert, and on the day that I tried to give up, I thought that my IQ had dropped by about 50 per cent. I wish the hon. Gentleman every success, although his performance today does not show that he is suffering from the effects of giving up smoking.

Dr. Richard Taylor: I am relieved that, in England at least, full implementation is slightly delayed until April 2003. However, we must face the fact that the change for GPs and PCGs that are turned into PCTs is huge. The paper that was circulated by the Minister entitled "Functions currently directly conferred on health authorities and transferred by the Bill", is a huge list of duties that go to PCTs. In my county, the three PCTs will be responsible for their own local services and each will be responsible for a huge list of county-wide services. My PCT will become responsible for children's services for the county. Will the Minister assure us that resources and expertise will be given to the PCTs by April 2003, so that they can take on the extra duties that, in the case of my trust, more than double the payroll of the staff for which it is responsible?

Mr. Oliver Heald (North-East Hertfordshire): I apologise for not being here earlier due to business in the House.

The purpose of the proposal is to have a failsafe mechanism to ensure that before a PCT is given functions, it is willing and able to receive them. There is also the timetable issue. A PCT must be ready, and we have already amply debated the lack of preparedness of some PCGs. The hon. Member for Wyre Forest (Dr. Taylor) touched on the range of functions that could be transferred to a PCT, as well as those that are delegated by the Secretary of State. A PCT could be ready to undertake some functions that it is given, but not others, such as recruitment or dealing with retention difficulties. Does the Minister see any reason why it would not be possible, in an appropriate case, to give a PCT only the functions that it is ready, willing and able to take on, or does there have to be a template solution, in which all the functions are transferred in one go? In other words, is it possible to have what used to be loosely described as variable geometry?

Mr. Hutton: No, I am not in favour of variable geometry. When I was at school, I never understood it, but with regard to the hon. Gentleman's argument it is clear that it would not be a recipe for consistency and effectiveness throughout the NHS. We must consider the issue in the context of the architecture of the new arrangements between SHAs and PCTs. The purpose of the exercise is to give the grass roots of the front-line services as many functions as possible. Of course, the Secretary of State has to make judgments about the capacity and the capabilities of PCTs to discharge such functions. That is precisely his function and it is part and parcel of the decision making process that he must go through in authorising the establishment of a PCT. That is the right way to discharge those functions effectively, rather than an attempt at variable geometry in the way that the hon. Gentleman proposed. I would not want to signal to the hon. Gentleman that we are considering variable geometry; we are not.

Mr. Heald: According to the list, the current health authority functions listed will go to the PCTs. One function relates to special notices of births and deaths. I do not know what that amounts to—the Minister may be able to tell me—but it is probably not one of the health authority's major functions. However, a PCT may have difficulty in sorting that out.

There may be some mechanism that we have not yet heard about whereby the Secretary of State would simply transfer functions when the trust was ready, and the special notices of births and deaths function would be transferred in due course when it was ready to go on line. It may be that that is one of the powers of the Secretary of State in the schedules. There certainly is a provision in one of the schedules to the effect that the Secretary of State has powers to distribute the functions in a very wide way. Is it possible for the Secretary of State to distribute these functions à la carte or does he have to do them all at once and is the mechanism—

The Chairman: Order. Unless I am wrong, the hon. Gentleman is intervening on the Minister and, if so, the intervention is somewhat excessive.

Mr. Heald: I must accept that I am guilty of excessive enthusiasm.

Mr. Hutton: We do not want to encourage any more of that, thank you very much.

In theory, that is possible because the Secretary of State can exercise that discretion, but it would not be sensible to do so in the context of what we are trying to achieve through shifting the balance of power. We envisage the PCTs taking on the responsibilities and that is why we have set out the provisions today and I have tried to expand upon them in earlier sittings of the Committee. If the hon. Gentleman wants to raise specific questions about the special notices of births and deaths, we shall certainly be able to reconsider the matter when and if we debate clause 3. I do not have any information about that at my finger tips, but I am sure that I can obtain it if he wants.

The amendment is essentially about whether the House should go through the affirmative resolution procedure when the Secretary of State wants to bring a PCT into existence and he has to make the statement that it is ready, willing and able to receive and exercise its functions. According to the amendment, he has only to make that statement, and I do not see how that is an improvement in the scrutiny role.

The issue of accountability is important; I do not dispute that. My view is that clearly, as the Secretary of State will hopefully be given powers to make these decisions under this legislation, he is accountable to the House for his decisions. There are various ways open to Members to hold the Secretary of State to account. This is a genuine question that we would need to be further satisfied about. I have no doubt at all that the Opposition Chief Whip will want to reflect on the question. I suppose it is different in opposition, but if the hon. Gentleman succeeded in amending the proposal and, by some miraculous turn of events, the Conservatives became the party of government, he would have to explain to his business managers why hundreds of orders have to be debated on the Floor of the House simply because the Secretary of State has to make a statement. With the benefit of 20:20 vision they might welcome such a proposition, but I strongly suspect that in reality they would not. Most Government Members probably regard the hon. Gentleman's point as a bit of window dressing, and not substantive.

The hon. Member for Wyre Forest made one important point, and I will deal with it. He asked me about functions and resources and, in particular, whether PCTs will have the resources to go with the functions. That is our intention. It is not part of our programme of NHS reform to give grass-roots primary care organisations important new functions but no means to deliver them. We are not stupid. He asked for a simple response, and I have given one.

Opposition Members must bear in mind that, although PCTs will be given new responsibilities, people in the NHS are already discharging them. In this matter, they tend to be working in health authorities. We envisage those people continuing to exercise important responsibilities in the new PCTs, and we want those who wish to transfer to do so. I hope that there is no misunderstanding. The functions are being discharged by public servants in the NHS, and they will continue to be discharged by public servants working for PCTs. The resources that are needed to ensure that the SHAs and PCTs can discharge those important responsibilities will be available.

Mr. Heald: The Minister may be labouring under a misapprehension of what we were aiming to achieve with amendment No. 123. He said that it would be wrong to deal with the matter under the affirmative resolution procedure because each order would have to be debated on the Floor of the House, but there would be no need for that. There would be a debate in Committee, similar to the one that we had on Monday, not on the Floor of the House, although there would be provision for seeking to divide the House after the Committee had examined it.

The procedural point is not the most important part of the amendment. If the Minister is saying that the amendment would be acceptable if it used negative procedure, we will examine that option for Report. Our point is that because many PCGs are not ready at the moment—concerns have been expressed widely about that—there should be a duty on the Secretary of State not to impose duties and burdens on PCGs that are not ready for them, or, if he does impose such duties, to make a statement to the House to the effect that they are not only ready, but willing and able to take on the functions. That is a sensible suggestion. If the Minister's only objection is that he believes that we should do that using negative procedure, I would be prepared to withdraw the amendment and reconsider it for Report.

Some current health authority functions, such as the management of family health services, are significant matters. Indeed, as the Minister may agree, it is one of the most crucial functions. General medical services are similarly important, and general practice plays a vital role throughout our constituencies. However, some functions are minor. I raised some points during my long intervention, and I have not yet had a satisfactory answer. I hope that the Minister will be prepared to take up those points briefly. He seems to suggest that all the functions would be given to the PCT at once. If a PCT can manage most of the functions but has difficulties with one or two aspects, for whatever reason, could not most of the functions be transferred? Or would they all have to be transferred because the health authority had been abolished and there was no one to take responsibility? We are keen to probe the practical aspects. It is part of the theme that we have developed throughout the Committee that not all the PCTs and PCGs are ready. We want to be satisfied that the Government have thought through all the issues.

4 pm

Mr. Burns: Given that the Minister seems reluctant to answer my hon. Friend's points, we will reserve judgment and reconsider the matter on Report. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Question proposed, That the clause, as amended, stand part of the Bill.

Mr. Heald: The clause is important because it deals with the key distribution of functions by the Secretary of State, both to the strategic health authority and to PCTs. It states:

"A Strategic Health Authority may, in relation to any specified functions of theirs, direct a Primary Care Trust whose area falls within their area to exercise those functions."

It also provides that

"a Strategic Health Authority may not so direct a Primary Care Trust in relation to any functions of the Strategic Health Authority arising under section 28C arrangements if the Primary Care Trust is providing any services in accordance with those arrangements."

It goes on to provide that the Secretary of State may direct strategic health authorities that specified functions are exercisable or not by PCTs.

The list that the Minister produced, for which I thank him, is helpful in detailing the functions that are currently directly conferred on health authorities and would be transferred by the Bill. Will the Minister comment on the general point that that distribution of functions is fine in that it gives the PCTs responsibility

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for important issues, such as the management of family health services, general medical services, and so on, but that it has to be seem in the context of the numerous target performance indicators and the fact that the Secretary of State retains numerous powers throughout the Bill? To what extent can the Minister help us with the programme for the transfer of those functions? I asked earlier whether each of the health authority functions would be transferred to the PCTs or whether one range of functions could be ready and another not, so that the changes could be stepped in over a period. Have I misunderstood the way in which that works? Is it a take-it-all or leave-it-all option?

No body other than the PCT can take on the functions. As I understand it, the proposal is to abolish the health authorities before the PCTs are set up. The Minister said earlier that there would be a gap between the strategic health authorities being set up and the PCTs coming into effect. Our original idea, based on the Library brief and "Shifting the Balance", was that all the events, including the transfer of functions, would happen on the same day. We would have completion, to use a conveyancing term: on the same day, the authority would pass its powers over, and the PCT would pick them up.

If I am right, and the strategic health authorities are being set up on 1 April 2002 but the PCTs—or some of them—will not be established until October that year or allocated a budget until April 2003, what happens to the distribution of functions?

Mr. Hutton: We have been over this ground. In April 2002, the Secretary of State will use his existing legal powers to complete a merger of health authorities along the boundaries of the proposed strategic health authorities. Clearly, there will not be strategic health authorities in the sense of the Bill at that time, because the Bill will not have passed through both Houses. Later, when the Bill receives Royal Assent—say, by October 2002—we can properly complete the establishment of the strategic health authorities, in accordance with the provisions. That is when the architecture will be symmetrical: the PCTs and the strategic health authorities will be in place and discharging the functions that we decide on in the House. That will complete the process; there will not be a gap, as the hon. Gentleman implied.

Mr. Heald: The point is that there will be a vesting date on which functions are distributed from the health authorities to the PCTs. Will the date be October 2002, or later? I understand that the health authorities will merge. At the moment, they have various powers and duties, which are either delegated to them by the Secretary of State or provided by law. If the health authorities retain all those powers and some of the PCTs have been set up, but not all of them, how are the functions distributed to the PCTs in the period between 1 April 2002, when the mergers occur, and the date when the Bill, assuming it becomes an Act, comes into force? In other words, what is the Government's scheme for distributing the functions, before the Bill has been passed? Perhaps the Minister understands; I do not.

We had all thought that 1 April 2002 would be the vesting date. Obviously, that was an over-ambitious view of the time needed for the Bill to become an Act. If that will not be the date, I do not understand how the PCTs will function in the period between now and whatever date is the vesting date. Will the Minister help me?

Mr. Hutton: I thought that I had. The hon. Gentleman is labouring the point and making a substantial mountain out of a very small molehill. He needs to refresh himself about the legislative context of the debate. The functions that are directly transferable to PCTs cannot be transferred until the Bill becomes law. Existing functions conferred by the Secretary of State under the National Health Service Act 1977 will continue to be discharged by health authorities until the process of establishing and delegating functions to PCTs is complete and the Bill becomes law.

Mr. Heald: Will the PCT, as an agent of the health authority, be able to carry out its role from April? In other words, is the clause legislative cover? Perhaps PCTs will acquire more powers in October. A budget must account for transferred functions, but PCTs do not yet know what their budget will be. They assume that it will be what was spent on a function in the previous year plus a bit extra, in line with pronouncements from the Government, the Chancellor and so on. Will the Minister explain how their functions and budget dovetail? If PCTs have a budget at the beginning of the financial year, they will be able to undertake their functions. If they start in October, how will that process work? Will there be a health authority budget for 2002-03, with part of the money given to the PCTs mid-year to help with the new functions? The British Medical Association and the Royal College of Nursing were told that the starting date would be April 2003. How does the timetable for implementation accommodate the functions and the money? Those factors are interlinked, and PCTs are concerned about the Government's intentions.

Mr. Hutton: Under existing legislation, the Secretary of State can directly delegate his functions only to health authorities, and further delegation to PCTs is carried out by health authorities. Certain excepted functions, which include provisions for the special secure psychiatric hospitals, arrangements for local representative committees and most family health service duties, cannot be delegated beyond health authority level. The clause will simplify the system in England by making all the Secretary of State's functions directly delegable to strategic health authorities and primary care trusts. It also removes the concepts of delegable and excepted functions and enables a strategic health authority to direct a PCT on the exercise of any functions.

The clause streamlines the exercise of delegating and dispersing functions throughout the NHS, and transfers significant responsibilities directly to PCTs.

To labour the point, the transfer completes the process of devolution, which was outlined in the 1997 White Paper and was further developed in "Shifting the Balance" and our most recent proposals, so the clause is important. The NHS plan was not just a programme of investment, important though that is. It also set out a process of reform, which will be greatly assisted by the clause. The clause makes a reality of that aspiration.

4.15 pm

The clause provides for the Secretary of State to delegate his own health functions directly to PCTs. The provision fully recognises the changing role of the front line. I understand that the Opposition have reservations about the speed of those changes and that they have some fundamental objections to the process of devolution itself. However, this is a very important clause that I hope hon. Members on this side of the Committee will be able to support.

The hon. Member for North-East Hertfordshire asked me a number of questions about functions, and I tried to deal with his question about the timetable. He also asked about resources and how they would be transferred.He referred to a vesting day; the day on which we implement clause 2 will be when we shift all the directly conferred functions. We currently intend to do that around 1 October 2002, so we are envisaging a vesting day in the way that he has described. I cannot confirm to the House that it will be 1 October—it may well be a Sunday—but it will done in October. That is when the functions will be transferred. All the key family health services will be directly conferred and all PCTs will be given the responsibility of delivering those important functions.

The hon. Member for Wyre Forest asked me about resources and, as in all spheres of life, this is the crunch. When the functions transfer, the resources have to transfer with them. It would not be sensible of me to go into the detail of how the precise resources will transfer to each PCT because I am not in a position to have that discussion today. The obvious and only logical position for us is to ensure that the necessary budgetary allocations are transferred on the day on which the functions are transferred.

I am happy to go into more detail at some future point with the hon. Member for North-East Hertfordshire. Perhaps he would like to come into the department, or perhaps he would like me to provide him with a briefing. However, the resource issue, the audit trail, where the money is going; all of these issues will be in the public domain. We have nothing to hide about that. Many of the earlier debates have again become crystallised in this clause. I have tried to respond to the hon. Gentleman's concerns as fully as I am able at the moment.

Mr. Heald: I understand that there is a question over the power of functions that are directly transferred to the PCTs—these functions are listed—but there is also a power for a strategic health authority to direct that a specified function shall be dealt with by the PCT. Are those functions the same ones as are set out in the document that has been given to the Committee, or are they a different group of functions? Subsection (2) talks about the Secretary of State's functions going to PCTs. Is that what the Minister was referring to when he talked about the vesting day, or does the subsection apply to both matters?

Mr. Hutton: The power for the strategic health authority to direct a PCT relates to any of its functions. It is important that there is an opportunity for that power to be exercised at some point. The difficulty is how we square devolving power to the front line while continuing to have a power of direction. We have thought about this very carefully; the alternative is to have the Secretary of State issuing directions from the centre. The hon. Gentleman and his hon. Friends will be the first to moan at me that that would mean micromanagement of the NHS by Ministers in Richmond house.

We need to have this power to ensure that the NHS does not become a free-for-all, and that the strategic health authority is able to have that power when necessary. However, it is a power that we have moved away from the Secretary of State down as close to the front line as we can. The power is given to the strategic health authorities. I do not have anything else to say about clause 3, so I shall sit down.

Mr. Heald: I am obviously trespassing on the Minister's good will, but I shall continue. The document on the functions directly conferred on health authorities and transferred by the Bill states:

"This table sets out those functions which are directly conferred by legislation on Heath Authorities. There is a large number of functions which are conferred on the Secretary of State by legislation, which can be delegated to Health Authorities. Some functions can, in turn, be delegated by Health Authorities to Primary Care Trusts. The Bill does not deal with these functions".

These include such things as ambulance services. It then goes on:

"It is expected that those of the Secretary of State's functions which are currently exercised by Health Authorities will be delegated by the Secretary of State instead to the Primary Care Trusts."

It then lists the current health authority functions and the bodies to which they will be transferred.

Clause 3 concerns directions and the distribution of functions. I may be wrong, but I believe that it is concerned with different functions from those in that list. However, it may not be. Is the Minister saying that the list in the document of the current health authority functions that will go to the PCTs is a list of the functions that the strategic health authority will direct the PCTs to do? If so, I can understand that. If not, could the Minister give us an idea of what functions are dealt with? Subsection (2) mentions the Secretary of State's directions and his functions, and the health authority's directions and functions are also mentioned. Is that what the document is about? Are those directions transfers?

Mr. Hutton: I thought that I had answered that question. The primary care trusts' functions go down various routes. Some are transferred directly by the Bill; some will be delegated to the PCTs by the strategic health authority or the Secretary of State. The power in clause 3 to allow the strategic health authority to

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make a direction to a PCT is exercisable by the strategic health authority in relation to any of the functions that the PCT is discharging. It does not matter by which route the functions go to the PCTs; directly under the Bill or down any other route. The power given in the Bill to make directions to the PCT is exercisable by the strategic health authority in relation to any of the functions that it is discharging.

Mr. Heald: Could the Minister write to me to explain the matter in a little more detail? Will he explain the relationship between the document on the functions that are currently directly conferred on health authorities and transferred by the Bill, and clause 3?

Mr. Hutton: I shall write to the hon. Gentleman and to the Committee.

Question put and agreed to.

Clause 3 ordered to stand part of the Bill.

Clause 4

PERSONAL MEDICAL SERVICES, PERSONAL DENTAL SERVICES AND LOCAL PHARMACEUTICAL SERVICES

4.30 pm

Mr. Hutton: I beg to move amendment No. 92, in page 3, line 41, leave out ' "behalf)," ' and insert ' "functions)," '.

This is another minor, consequential amendment. Clause 4 removes the current bar on the Secretary of State delegating his own powers in respect of PMS and PDS pilot schemes by inserting a new subsection (1A) into section 9 of the National Health Service (Family Care) Act 1997. However, subsection (1A) does not take account of the fact that section 9(1) was amended by the Health Act 1999. In the amended section 9(1), the words "functions on his behalf" were replaced by "his functions". Amendment No. 92 corrects that minor drafting error, so that the new subsection (1A) applies the wording of the existing section 9(1A) as amended by the Health Act.

Amendment agreed to.

Question proposed, That the clause, as amended, stand part of the Bill.

Mr. Heald: Clause 4 deals with the important subject of personal medical services and local pharmaceutical services. I want to ask about the implications of the clause for Wales. There is concern about maintaining a level playing field between the nations on issues such as pharmaceuticals. The National Assembly for Wales has recently set up an all-Wales medicine strategy group to evaluate medical techniques and medicines, in much the same way as the National Institute for Clinical Excellence does. The group intends to issue its own guidance that will apply even if NICE is considering an issue. Will the National Assembly for Wales be able to allot money for pharmaceutical services differently from such allocations in England and, if so, will the Minister give his view on that? Is there not some concern that, with the advent of such changes, important medicines could be available in one country but not in another? What are the implications of having different sets of guidance?

Mr. Hutton: I am always happy to talk about clause 4, which is a familiar friend of mine. As we have discussed, the Bill will transfer almost all primary care functions of existing health authorities to PCTs. That lies at the heart of the initiative to shift the balance of power. However, there is a technical and legal tension between the principle of shifting the balance of power in the NHS and the legal architecture of the National Health Service (Primary Care) Act 1997, with which the hon. Gentleman may have had some involvement.

We do not need to look today at the origins of that Act, but the underlying principles of PMS and PDS are correct. The architecture of the 1997 Act has not prevented the Government from using PMS to extend the reach of primary care services through a range of important and innovative ideas to many parts of the country, including run-down council estates where residents never had access to primary care services.

As I implied earlier, the legal structure of the 1997 Act prevents us from using the Bill to transfer all the functions in respect of PMS and PDS to primary care trusts. Of course, we could have chosen to do that, but only by requiring Parliament to scrap the 1997 Act and by rewriting the entire legal framework around the delivery of personal medical services. That would have diverted Parliament from discussing more important issues, but there is another way of doing it; the way that we have chosen in clause 4.

The heart of the problem is that the 1997Act requires a distinction to be made between the commissioner and the provider of PMS or PDS. For example, in the majority of PMS pilots, the commissioner is the primary care trust and the provider a GP, a group of GPs or a nurse-led organisation. In some pilots, the primary care trust itself is the PMS pilot provider and the health authority is the commissioning organisation. To transfer all the local authority PMS functions directly to a primary care trust would, in such cases, result in a primary care trust commissioning PMS from itself. Obviously, we cannot accept that. It would not comply with the 1997 Act, and would go directly against the grain of that legislation. The options are either to rewrite the Act or to confer limited functions in respect of PMS or PDS on strategic health authorities.

Mr. Heald: Boiled down, the Minister's objection is that it would interfere with the internal market. Is that right?

Mr. Hutton: No, it is not right. This is a sensible divide. Under the legislation put in place by the hon. Gentleman's party, it would not be possible to do what we want to do without vandalising the legislation. There is a sensible reason to separate the functions in the manner that I have described. The Government do not subscribe to the principles of the internal market

or to the mechanisms that the hon. Gentleman's party put in place to deliver them because they were a shambles. They littered the NHS with bureaucracy and created armies of people sending bills and chasing invoices. None of us wants to go back to that. Perhaps the hon. Gentleman does, but I do not think that he would find himself able to stand before a Committee, armed with a raft of supportive comments from outside organisations, if he were minded to go down that path.

The principle behind clause 4 is clear, although this is a complex area for legislation. The hon. Gentleman asked about Wales and local pharmaceutical services. The Health and Social Care Act 2001 certainly applies to Wales in relation to LPS. My understanding is that the National Assembly for Wales has not yet decided whether to use those powers. As a result of the Bill, it will be possible to delegate LPS functions—for which we took powers from the Health and Social Care Act 2001—but because we are at an earlier stage in relation to LPS than we are with PMS, we shall invite proposals for the first LPS schemes early next year. We do not intend to delegate the approval of LPS pilot schemes to strategic health authorities at this stage.

I hope that I have dealt with the hon. Gentleman's concerns and I commend clause 4 of the schedule to the Committee.

Mr. Heald: I am grateful to the Minister for his explanation of the general provisions of clause 4. However, I do not think that he has amply responded to my specific concern about pharmaceuticals. The LPS services are governed by the same Act in both countries. I understand that Wales is developing a method of evaluating medical techniques and medicines that is parallel and similar to NICE, which gives guidance in this country. There must be a significant bearing on local pharmaceutical services if the guidance is different in the two countries. How will the Minister reconcile that? Is it something that the Government agree with? Are they happy to run two schemes either side of the border? Is the Minister not happy with it? Does he think that it is not a problem? What is the position with regard to the guidance that is to be given? Will it affect the costs for medicines and the way in which doctors look at medicines?

If NICE states that a medicine is clinically excellent, good value for money and affordable, a lot of doctors and hospitals might think, "Well, if I could afford it, I would try to use that medicine." Similarly, if NICE does not approve a drug, that is a problem for the company that makes it, and it has ramifications round the world. If the National Assembly for Wales has a body that performs a similar function to NICE but is quicker—the Assembly's motivation seems to be to get answers more quickly and, perhaps, to reduce the medicines bill in Wales—the guidance in Wales could end up differing from the guidance in England. That must have an impact on local pharmaceutical services. Given that the clause deals with that issue, surely the Minister is able to tell us the implications.

Mr. Hutton: There is a familiarity about what happens in these debates whenever the subject of Wales comes up. The reluctance to discuss matters is surprising, because I thought that Conservatives were the new force for the new age. It is surprising that that party is still fundamentally resisting what devolution involves. Devolution means the Government in Westminster deciding what is appropriate for the national health service in England, and the National Assembly for Wales making similar decisions for Wales within its remit.

That is the devolutionary settlement. The hon. Gentleman has problems with that and I am sorry that I cannot help him. [*Interruption.*] Conservative Members say that they do not have problems with the settlement, but they always do, because they cannot understand that there might be a difference between the way in which the National Assembly approaches the discharge of its functions and how we in England, and the Secretary of State, approach that. I have dealt with the point about the LPS scheme in England, for which I am accountable to Members of this House. The hon. Gentleman knows perfectly well that I am not accountable for the decisions of the National Assembly for Wales. It takes its decisions within the framework of the primary legislation determined in this House; that is what it intends to do in relation to LPS.

Mr. Heald: There is no need for the Minister to get touchy. I am asking him what the implications are, which I would have thought was a good thing. The Opposition has been rather helpful today in ensuring that important Welsh matters were debated, when there was precious little time. We agreed to a change in the programme motion so that those matters could be discussed. We are not criticising; we are asking what the implications are. From what the Minister has said, the implications are that certain medicines will be provided on one side of the boundary between the two countries and perhaps not on the other, and he is content with that.

Mr. Hutton: With great respect to the hon. Gentleman, he is putting words into my mouth. I made it clear to him, and to the Committee, that the National Assembly for Wales is responsible for the decisions that it takes under the Health and Social Care Act 2001 in relation to LPS. I am not accountable for that. The National Assembly's decisions have no implications for his constituents or mine, who use the NHS in England. If he is asking me to assess the implications for the NHS in England, I can tell him that there will not be any. He is also wrong in his description of NICE and the applicability of its guidelines, because the NHS in Wales follows those guidelines. It is mischievous of him to suggest, in relation to the clause, that we are proposing a legislative framework for access to medical treatment and drugs that will discriminate against people either in Wales or in England. That is not true.

Mr. Heald: I am genuinely shocked. I asked a simple question, and wanted some elucidation. It is my understanding that the National Assembly is setting

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up the all-Wales medicine strategy group and that that body will evaluate medical techniques and medicines in much the same way as NICE. I also understand that it will issue its own guidance, ahead of NICE, if NICE is considering an issue. If I am wrong and NICE's guidance will be followed in Wales, the Minister has only to tell me and I shall be pleased with that elucidation. However, he does not seem to be saying that. He seems to be saying that NICE guidance will still apply in Wales; he implies that I am wrong, but does not say so directly. The Under-Secretary of State for Wales is present, and I would be grateful if he described the position of the all-Wales medicine strategy group. It is a fair subject to consider in connection with the important developments in local pharmaceutical services.

Mr. Touhig: I can add nothing to what my right hon. Friend the Minister for State has made clear. I cannot understand why the hon. Gentleman cannot take on board what has happened with the devolution settlement. It has been explained and explained. Perhaps we need to hold a tutorial on the subject.

Mr. Heald: Imagine my confusion. The Minister of State said that NICE applied to Wales, as I thought. However, I am seen as mischievous and unfair because I pointed out something that I believed to be true, which was that the all-Wales medicine strategy group would do the same sort of work as NICE. I asked how the two interact, but Ministers seem defensive and suggest that I am criticising Wales or the National Assembly. That is not so. I am asking how the groups relate, and they ought to know.

Mr. Hutton: The hon. Gentleman is labouring the point. I do not know whether he has ever raised his concerns with NICE; I suspect not. [*Interruption.*] He says that he has only had concerns since yesterday, but we need not to dwell on that observation. It might be educational and informative for him to study what the NICE guidelines say about applicability to Wales. I shall arrange for him to see them so that he can see how the system works. NICE can apply its recommendations differentially, which is how it has always approached its task. The NICE guidelines apply to Wales unless specified otherwise. For the life of me, I cannot understand the point on which he is detaining the Committee.

Mr. Heald: I think that the Minister understood the point only too well, but could not answer it.

Mr. Peter Atkinson (Hexham): My hon. Friend has not had a great deal of success with the Minister, so I shall try to help by simplifying the question. Perhaps he should ask what the all-Wales medicine strategy group does.

Mr. Heald: If other members of the Committee want me to ask that question, I am happy to ask the Minister or the Under-Secretary to explain the role of the all-Wales medicine strategy group.

Mr. Hutton: The Opposition are getting to the point of puerility. The question has nothing to do with the schedule and clause. As the hon. Gentleman knows because he has read the documentation, the National Assembly for Wales is responsible for the working of the strategy group, so it determines its functions, roles and responsibilities. That is the proper constitutional settlement.

Mr. Heald: What an extraordinary thing. We are here with a Minister of State in the Department of Health, the Under-Secretary of State for Wales and an army of civil servants, but we cannot be told what a certain body does when we are considering a clause that mentions "local pharmaceutical services" in its title. The Minister of State tells us that pharmaceutical services have been set up under legislation that applies to England and Wales. We have set aside time this afternoon specifically to consider the situation in Wales because we accept that it is important, yet neither Minister knows what the all-Wales medicine strategy group does.

Question put and agreed to.

Clause 4, as amended, ordered to stand part of the Bill.

Schedule 3

AMENDMENTS RELATING TO PERSONAL MEDICAL SERVICES AND PERSONAL DENTAL SERVICES

4.45 pm

Mr. Hutton: I beg to move amendment No. 107, in page 59, line 13, at end insert—

'*The 1977 Act*

In section 15 of the 1977 Act (duty of Health Authority in relation to family health services), in subsection (1ZA), after "duty of" there is inserted "each Strategic Health Authority and".'

The Chairman: With this it will be convenient to take Government amendments Nos. 108 to 111.

Mr. Hutton: Once again, I am afraid that I have to bring several minor and consequential amendments to the Committee's attention. The amendments are minor, and are either consequential on the transfer to a strategic health authority of the functions of a health authority in relation to PMS and PDS, as set out in schedule 3, or they are tidying-up measures. To provide consistency in the Bill, amendment No. 107 extends the duty to perform any functions in relation to PMS and PDS prescribed in regulations made under section 15(1ZA) of the 1977Act to a strategic health authority. That is in line with the transfer of PMS and PDS functions, as set out in the schedule.

Amendment No. 108 makes a similar consequential change to the Trade Union and Labour Relations (Consolidation) Act 1992, which includes in the definition of worker those individuals who perform PMS and PDS in accordance with arrangements made by a health authority. The amendment simply takes

account of the fact that such arrangements will be made by a strategic health authority, rather than a health authority.

Amendment agreed to.

Amendments made: No. 108, in page 59, line 23, at end insert—

'The Trade Union and Labour Relations (Consolidation) Act 1992 (c. 52)

In section 279 of the Trade Union and Labour Relations (Consolidation) Act 1992 (health service practitioners), in paragraph (a), after "by a" there is inserted "Strategic Health Authority,".'.

No. 109, in page 59, line 30, at end insert—

'The Health and Social Care Act 2001 is amended as follows.'

No. 110, in page 59, line 31, leave out 'of the Health and Social Care Act 2001'.

No. 111, in page 60, line 17, at end insert—

'In Schedule 1 (exempt information relating to health services), in paragraph 11, after "request to a" there is inserted "Strategic Health Authority or".'—[*Mr. Hutton.*]

Schedule 3, as amended, agreed to.

Clause 10

EXPENDITURE OF NHS BODIES

Question proposed, That the clause stand part of the Bill.

Mr. Heald: Will the Minister outline the effect of the clause?

Mr. Hutton: Schedule 12A of the National Health Service Act 1977 defines the expenditure of health authorities and primary care trusts. It also provides health authorities with the authority to apportion drug costs to primary care trusts. Clause 10 will amend schedule 12A so that PCT expenditure mirrors that of the current health authorities and will give the Secretary of State the authority to apportion drug costs between the PCTs. He must have that function because the resources will pass directly from him to the PCTs. There is no longer any residual role for the health authorities in that process because of the way in which the transfer of resources will be carried out in the NHS. The clause also allows the existing health authority position to be preserved in Wales and defines expenditure for local health boards.

Mr. Heald: I understand the apportionment of costs for medicines, but will the Minister explain how it operates in the terms of the relationship between England and Wales?

Mr. Hutton: I suspect that I shall have to write to the hon. Gentleman about that.

Mr. Heald: I am grateful. I am sorry to hark back to this, but if the all-Wales medicine strategy group issues guidance that allows beta interferon to be prescribed in Wales and a prescription is subsequently presented to an English pharmacist and is accepted, what will happen to the allocation in the authority areas?

Mr. Hutton: I am not sure that I shall be able to answer every point that the hon. Gentleman raised. However, it might be helpful if I explained one or two points by way of background.

Clause 10 deals with two issues. The first is the division of PCT expenditure between that which is subject to resource and cash limits and that which is funded on a demand-led basis. The second is shifting expenditure on prescribed drugs from the PCT that is responsible for dispensing them to the PCT that is responsible for prescribing them. Once upon a time, all family health service expenditure fell outside the scope of the main allocations made to health authorities, and were funded separately on a demand-led basis. However, as a matter of policy, elements of family health services have been brought within the scope of health authority allocations and the discipline of resource and cash limits.

Present schedule 12A of the NHS Act provides the legal basis for dividing the expenditure of health authorities into two principal categories. The first is main expenditure, which is the legal term for expenditure that falls within the scope of health authority allocations. The second is general part II expenditure, which is the legal term for family health service spending that falls outside the scope of health authority allocations and is still funded on a demand-led basis.

Currently, health authorities are responsible for arranging the provision of pharmaceutical services. Accordingly, the cost of prescriptions initially hits the health authority responsible for the chemist that dispenses the prescription. The cost of drugs is included in the allocations of health authorities on the basis of the need of their populations to have drugs prescribed for them. The present schedule 12A provides the legal means of transferring the cost of drugs from the health authority where they were dispensed to the health authority where they were prescribed. As PCTs are taking over responsibility for family health services, including pharmaceutical services, clause 10 must amend schedule 12A, so that the cost of drugs can be transferred from the PCT that is responsible for the dispenser to the PCT that is responsible for the prescriber.

I know that that is not an answer to the hon. Gentleman's point, but I hope that it explains some of the processes involved more fully than my original remarks did. The hon. Gentleman asked me for more information about the exact nature of the process for apportioning costs, and I am happy to write to him about that.

Mr. Atkinson: I should like to pursue a similar theme with the Minister and to raise the relationship between England and Wales. Whatever happens in that relationship will presumably happen later in the relationship between England and Scotland. That would affect me because my constituency borders Scotland.

New paragraph 6C(3) states that

[Mr. Atkinson]

"in any financial year any remuneration referable to the cost of drugs for which a Local Health Board is accountable is paid by another Local Health Board, the remuneration is to be treated...as having been paid by the first Board in the performance of its functions."

I understand how that will work perfectly well within Wales, but what happens if a health authority across the border is involved? Will money be transferred from one country to another to repay an English health board that pays for drugs?

Mr. Hutton: The hon. Gentleman will be aware that arrangements are in place to cover that eventuality, and I shall write to him with the details. However, the Bill does not and cannot change the legislation on the operation of any part of the NHS in Scotland because that is a fully devolved issue. The hon. Gentleman is right to say that part of the clause relates to Wales. It allows Wales to preserve existing health authority arrangements. Those arrangements define part I and part II expenditure for local health boards, which will mirror the definition used by current Welsh health authorities.

Dr. Richard Taylor: Can the Minister allay my concerns? Is there any change in the range of measures that will be subject to cash limits?

Mr. Hutton: No.

Question put and agreed to.

Clause 10 ordered to stand part of the Bill

Further consideration adjourned.—[*Mr. Fitzpatrick.*]

Adjourned accordingly at seven minutes to Five o'clock till Tuesday 4 December at half-past Ten o'clock.

THE FOLLOWING MEMBERS ATTENDED THE COMMITTEE:

Hurst, Mr. Alan (*Chairman*)
Atkinson, Mr. Peter
Baron, Mr.
Burns, Mr.
Challen, Mr.
Fitzpatrick, Jim
Hall, Mr. Mike
Havard, Mr.
Heald, Mr.
Hutton, Mr.
Moffatt, Laura
Murrison, Dr.
Taylor, Dr. Richard
Touhig, Mr.
Ward, Ms

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